

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040029

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

5600

STATE FILE NUMBER

FILED NOV 4 1963

1. PLACE OF DEATH a. COUNTY <b>Jackson</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Jackson</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Kansas City</b>		c. CITY OR TOWN <b>Kansas City</b>	
Length of stay in 1b <b>45 yrs.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <b>Downtown Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>2615 East 11th St.</b>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <b>Mr. ROY B. McCLAIN</b>			4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>1963</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-26-1896</b>	9. AGE (last birthday) <b>67</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Eagles employee</b>			12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
10b. KIND OF BUSINESS OR INDUSTRY <b>Fraternal</b>			11. BIRTHPLACE (City and state or country) <b>Topeka, Kansas</b>		

13a. FATHER'S NAME <b>William Frederick McClain</b>		13b. MOTHER'S MAIDEN NAME <b>Catherine Poland</b>		14. NAME OF HUSBAND OR WIFE <b>Elizabeth E. McClain</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>			17. INFORMANT Address <b>Elizabeth E. McClain - 2615 East 11th St.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 months</b>
DUE TO (b) <b>Coronary Sclerosis</b>		<b>16 months</b>
DUE TO (c) <b>Hypertensive cardiovascular disease</b>		<b>19 years</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>6:25</b> a.m. <b>4-7-62</b> Month, Day, Year		20f. CITY, TOWN, OR LOCATION <b>10-1-63</b>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from <b>4-7-62</b> to <b>10-15-63</b> and last saw her alive on <b>10-1-63</b>		Death occurred at <b>6:25</b> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS <b>1222 McGee, Kansas City, Mo</b>		22c. DATE SIGNED <b>10-16-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-17-63</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>	
24. FUNERAL DIRECTOR <b>Mellody-McGilley-Eylar Funeral Home</b>		25. DATE RECD. BY LOCAL REG. <b>10-16-63</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
ADDRESS <b>Linwood &amp; WOODLAND</b>		(Licensed Embalmer's Statement on Reverse Side)			

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

5/27/64

499-09-5844

499-07-5844

BY AFFIDAVIT OF Informant  
Cutliff  
DOCUMENT Certificate of Social Insurance Award

MEDICAL CERTIFICATION

Dr. D. J. Cuttiff  
1222 Mc Lee  
HA1-2388

after 10. AM Wed.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

James R. Phillips

Licensed Embalmer No. 4641

P. O. Address. K.C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above: